Washington State
Department of Social
& Health Services

**Report to the Legislature**

# Workplace Safety in State Hospitals

RCW 72.23.450

September 1, 2002

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# REPORT TO THE LEGISLATURE
# WORKPLACE SAFETY IN STATE HOSPITALS

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## BACKGROUND

Chapter 72.23 RCW requires each state hospital to develop a plan to reasonably prevent and protect their employees from violence at those hospitals and directs the Department of Social and Health Services (DSHS) to provide an annual report to the legislature on efforts to reduce violence in the hospitals.

Specific statutory language follows:

**RCW 72.23.400(1)(4) – Workplace safety plan.**

(1) By November 1, 2000, each state hospital shall develop a plan, for implementation by January 1, 2001, to reasonably prevent and protect employees from violence at the state hospital. The plan shall be developed with input from the state hospital's safety committee, which includes representation from management, unions, nursing, psychiatry, and key function staff as appropriate. The plan shall address security considerations related to the following items:
   (a) The physical attributes of the state hospital;
   (b) Staffing, including security staffing;
   (c) Personnel policies;
   (d) First aid and emergency procedures;
   (e) Reporting violent acts, taking appropriate action in response to violent acts, and follow-up procedures after violent acts;
   (f) Development of criteria for determining and reporting verbal threats;
   (g) Employee education and training; and
   (h) Clinical and patient policies and procedures.

(4) The plan must be evaluated, reviewed, and amended as necessary, at least annually.

**RCW 72.23.450 – Annual report to the legislature.**

The department shall provide an interim report on the progress of the plan development to the legislature by July 1, 2000 and a copy of the completed plan by November 1, 2000. The department shall thereafter provide an annual report to the legislature on its efforts to reduce violence in the state hospitals not later than September 1st of each year.

Initial workplace safety plans were submitted to the legislature November 2000 and have been implemented in each of the three state hospitals:

Western State Hospital (WSH) is located in Lakewood and has a capacity of 959 beds;

Eastern State Hospital (ESH) is located in Medical Lake and has a capacity of 302 beds;

Child Study and Treatment Center (CSTC) is located on the grounds of Western State Hospital in Lakewood and has a capacity of 47 beds.

Those plans have been evaluated, reviewed, and amended and are submitted as appendices to this report. The plans detail the outcome of safety and security assessments and resulting plans of action. Each hospital's ongoing security and safety assessment reveals separate and distinct needs addressed in respective plans. Provided as an additional source of information is supporting data related to patient-to-staff assaults, industrial insurance claims submitted and time loss due to injury.

## WORKPLACE SAFETY PLANS

Creating the safest possible work environment in Washington's state hospitals is a top priority for the Department of Social and Health Services (DSHS) leadership, the department's Mental Health Division, the Department of Labor and Industries (L&I), local unions, and state hospital managers. Collaborative efforts have resulted in state hospital workplace safety plans that focus on reducing the number and severity of assaults against staff by patients.

Workplace safety plans were developed under the auspices of the Mental Health Division Quality Steering Committee. The committee established goals that are used as the foundation to assess and to continue to implement the plans in each of the three state hospitals. Staff from each state hospital, including representatives from labor and management, work as a team to accomplish the established goals listed below:

- Reduction of staff assaults;
- Reduction of compensable claims;
- Reduction of time loss due to assault;
- Review and analysis of trend data to help direct and support organizational decisions;
- Establishment of training programs to address individual safety/security issues; and
- Establishment of mechanisms for ongoing safety and security assessment.

## COLLABORATIVE EFFORTS TO IMPROVE WORKPLACE SAFETY

The following information summarizes numerous collaborative efforts to improve workplace safety in the three state hospitals:

- Physical security and safety assessments are conducted annually at the three hospitals and recommendations from these assessments are included in each hospital's safety plan update. Safety Committees and/or Executive Management of each state hospital monitor the progress of work place safety plans and the Hospital Governing Body reviews quarterly reports on claims data.

- Funds received through the Department of Labor and Industries, Safety and Health Impact Grant Program, were used to begin development of peer mentoring/training programs for behavior management techniques. Nursing staff was identified as a priority under the emergency management plan update with Registered Nurses and Licensed Practical Nurses trained first. The grant provided advanced training for staff in critical incident response and intervention techniques.

  Note: The 01-03 operating budget does not include any appropriation for the Safety and Health Impact Grant Program.

- WISHA Safe At Work grant dollars will be pursued each year for four years in an attempt to continue funding for training and back-fill of staff in order to sustain an infrastructure to uphold the mentoring/training concept. The hospitals note that this training requirement is increasingly difficult to meet due to problems with recruitment and retention of licensed staff. High staff turnover keeps the hospitals in a constant training mode and presents difficulties with providing ward coverage during training events. Training developed and funded by the WISHA Grant Program for direct-care staff in identified high-risk areas was completed June of 2001. The majority of grant dollars were utilized for back-fill coverage costs for those being trained.

  Note: The WISHA Safe At Work Grant was not renewed for FY 01-02.

- Staffing levels remain within national accreditation and certification standards. As budget allocations, treatment models, census and patient acuity levels change, staffing ratios will be adjusted accordingly.

- Salary increases appropriated by the legislature provided for substantial raises for certain licensed categories in January 2002. However, some salaries remain far behind those in community facilities. Community facilities are also recruiting actively and facing the same personnel shortages.

- Behavioral management and violence prevention training for staff is mandated prior to a ward-based assignment in all three hospitals. Training programs have been modified to include the fourteen elements addressed in RCW 72.23.400(1). The goal of the training is to prevent incidents of violence and reduce injuries to employees.

- Hospital policies related to personnel, safety, smoking, leisure and therapeutic programs, communication between shifts, restraint and seclusion are reviewed with an emphasis on reduction of work place violence. This has resulted in revision and clarification of some policies.

- The state hospitals are continuing to work toward significant reduction in the use of seclusion and restraint interventions. Revisions are being made to the hospital seclusion and restraint policies and procedures. Staff receive inservice training on the application and use of restraint interventions to focus on safety of staff, the patient, and other patients on the ward. In addition, there is an increased emphasis on use of less restrictive alternatives to contain patient behavior such as early intervention and

positive behavioral supports. This approach is expected to increase safety by diffusing crisis situations before violence erupts. Reductions in seclusion/ and restraint intervention use have been noted.

- The hospitals have placed a major focus on decreasing unstructured time for patients. Therapeutic and leisure activity programs have been increased to cover weekend and evening shifts. Ongoing review of milieu programming has led to a number of specific actions with a focus on quality improvement to increase recreation participation hours of patients. A focus on increased structure and supervision has greatly contributed to the decrease in use of seclusion interventions in the adult hospitals. Program structure and intervention techniques that address staff safety have been assessed.

- Procedures for reporting violent acts/threats and follow-up to reports have been revised and strengthened. This training is provided to new employees to help in identifying and reporting violence in the work place and will remain a consistent part of the curriculum for all new employees. This training has resulted in a significant increase in reporting of high-risk incidents.

- Data is analyzed and monitored to help direct and support organizational decisions. For example, it has been recommended that all supervisors be trained to identify the need for posttraumatic stress assistance services in their subordinates after a crisis situation. A detailed analysis of recent incidents of violence toward staff and property was also initiated in May 2002 to identify the circumstances that lead to high-risk incidents and to identify knowledge, skills and resources needed to address these situations.

- All hospitals have obtained communication and/or violence prevention equipment such as personal alarm devices, radios, padded shields, and paging devices.

  At ESH, patients are escorted to dining areas during meal times by staff who are equipped with portable radios for communication.

  At WSH, a personal alarm pilot program was implemented in October 2001 at the Center for Forensic Services. Evaluation shows high staff satisfaction with the system. Response time to emergency situations during the pilot period was cut by two thirds. Plans for installation of a hospital-wide system are currently ongoing at WSH.

- Distribution of information on the spillover effects of domestic violence in the workplace is given to all new employees during orientation and is periodically inserted into staff paychecks.

The attached workplace safety plans for each state hospital detail the outcome of safety and security assessments and the resulting plans of action. The workplace safety plans are working documents at each hospital and remain a top priority for hospital management.

## RESULTS

### Reduction of staff assaults

The goal of reducing the number of patient-to-staff assaults was met for the period of July 2001 through June 2002 (See Appendix D). Data collection began with implementation of the plans in January 2001. Incidents of violence against staff are monitored monthly. With enhanced reporting procedures and follow-up processes, an increase in reporting in the first few months is evident; however, there continue to be reporting variations among the hospitals. Anomalies are referred to the quality steering committee for analysis and direction. Continuing the downward trend in patient-to-staff assaults will be a key indicator for the FY03 Mental Health Division quality management plan.

### Reduction of compensable claims

According to DSHS Office of Risk Management data, compensable claims are occurring at about the same rate as in 2001 (Appendix E). However, source data from Labor and Industries also includes non-compensable claims. Thus, the data for patient-to-staff assaults used in appendix D is not directly comparable to the data reported in Appendix E. Also, L&I uses data based on estimates, which do show a leveling off of claims over time.

### Reduction of time loss due to assault

According to DSHS Office of Risk Management data, there has been a reduction in overall time loss and cost (Appendix E). However, this data is global in nature and not directly related to assaults. The most recent data is based on L&I estimates which are subject to change as claims are resolved. It may take up to two years for claims to close and to complete the data. However, it is worthy to note that the most recent data show that time loss days do level off.

### Review and analysis of trend data to help direct and support organizational decisions

Hospital Quality Management Departments and Executive Management teams review and analyze trend data at least quarterly to assist in directing and supporting organizational decisions.

### Establishment of training program to address individual safety/security issues

Staff Development Departments in all three hospitals have reviewed the new employee orientation curriculum, as well as annual update procedures. Each hospital has made modifications where needed.

### Establishment of mechanism for ongoing safety and security assessment

Each hospital's plan describes their respective mechanism for ongoing safety and security assessment. Collaboration among hospitals, labor, and management has resulted in sharing of ideas and resources, which ultimately is reflected in the plans.

# APPENDICES

# Appendix A - Workplace Safety Plan (WSH)

## Western State Hospital

**UPDATE**
**May 15, 2002**

RCW 72.23.400 requires each state hospital (WSH, ESH, CSTC) to develop a plan to reasonably prevent and protect employees from violence. The law requires completion of a security and safety assessment to identify existing or potential hazards for violence in the workplace. Using the results of the assessment, each state hospital must develop a plan to prevent and protect employees from violence and provide an update to the legislature annually. The following table lists the elements of both the assessment and the updated plan as required by law. It then provides a summary of the results of the assessment as well as the plan derived from that assessment.

| **Elements of the plan per law.** (Items a through h below are part of the security & safety assessment) | **Assessment** – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence. | **Plan** – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence. |
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| a. The physical attributes of the state hospital including:<br>1. Access control<br>2. Egreess control<br>3. Door locks<br>4. Lighting<br>5. Alarm systems | Physical security tour of Western State Hospital (WSH) campus revealed the following:<br>• Access, egress control and door locks were found to be generally in good order. Conducted as part of the First Annual Lakewood Fire Marshal Inspection, December 2001- May 2002.<br>• All fire exit doors in Center for Forensic Services (CFS) in South Hall were found to be a potential risk for escape.<br>• First Annual Lakewood Fire Inspection to be conducted. | • Maintenance Department will monitor and prioritize work requests to maintain current condition. Annual assessments of access control, egress control, door locks, lighting, and alarm systems will be conducted by the Environment of Care Committee.<br>**Target: Annually in September**<br>• All fire exit doors in the CFS have been wired to immediately alert security stations if opened. New CFS Building will further upgrade situation.<br>**Target: Completed**<br>• First annual Lakewood Fire Inspection completed by Lakewood Fire Marshall and team from WSH comprised of Safety Officer, Facilities Representative, and others as needed. The Inspection covered the Months of December, 2001 through May, 2002. This assessment was valuable for evaluation of locks, access, and egress control issues. Many shortcomings were repaired and debris buildup removed to preclude a fire emergency. |

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| | • More strict enforcement of Identification Badge Policy is needed. | • All supervisors are directed to strictly enforce the wearing of ID badges for all staff and visitors. Added to new employee hospital orientation curriculum.<br>**Target: Completed ( on-going )** |
| | • Lighting is adequate on all wards, offices, and shop areas. Outdoor lighting is adequate in the new area. | • Lighting has been added to two outlying areas. Maintenance Department is responsible to ensure lighting is maintained regularly. Selected trees and shrubs have been removed. Ongoing monitoring will be conducted by the WSH ground maintenance crew.<br>**Target: Ongoing** |
| | • Alarm systems – Minimally, all high-risk wards require a personal alarm device system for immediate alert for assistance during assault/crisis. Response times for crisis assistance can be cut significantly as demonstrated by the CFS Pilot Program. | • Improvement of Organizational Performance (IOP) group was chartered to conduct a nationwide comparative study on various personal alarm device systems. The study was completed and Headquarters accepted the group's recommendation. Capital Programs approved funding for a pilot and a three-phase installation process. The pilot project was completed in October 2001 with high staff satisfaction, and response time cut by 2/3. Full use in CFS (both South Hall and New CFS Building). Planning for phased in installation of system Hospital wide currently on-going.<br>**Target: September 2002** |
| | • Upgraded and additional communication equipment is a growing need (radios, walkie-talkies) on various units throughout the hospital. High-risk areas are adequately stocked and staff is fully trained to use communication equipment. | • All current communication equipment has been inventoried and placed in high priority areas. Through budget planning and as funding becomes available, assessed needs will be covered with new purchases. Eighteen (18) hand-held radios were purchased and distributed during last year. New battery backup equipment being installed for hospital switchboard.<br>**Target: Biennial Budget Forecasting** |

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| b. Staffing, including security staffing | • Center for Medicare Medicaid Services (CMS) and Joint Commission on Accred- itation of Healthcare Organizations (JCAHO) inspections regularly include staffing assessments in terms of meeting the needs of the patients. Exceptional staffing needs are considered when variances occur in census and /or acuity levels, at which time nursing management revises the demands. Nursing management constantly monitors staffing for safe staffing levels. | • Staffing practices will remain within CMS and JCAHO standards. As budget allocations, treatment models, census and acuity change, staffing levels will be adjusted accordingly and within the standards of those two agencies.<br>**Target: Biennial Budget Forecasting** |
| | • Recruitment and retention continue to be a major problem. Major emphasis again is placed on the need to focus on recruitment and retention efforts in difficult-to-retain/recruit licensed job classes to ensure adequate expertise is available on all wards. 6767 funding provided for substantial raises for certain licensed categories in January 2002 but salaries still are far behind those in the community facilities which are also recruiting actively and facing the same personnel shortages. | • Continue to aggressively pursue with Department of Personnel (DOP) for comparable salaries for difficult-to-recruit/retain job classes. Continue marketing tactics to raise workforce in these areas to even higher levels to increase expertise in behavior management.<br>**Target: Unable to Determine – External control** |
| | • Initial organizational chart review is completed. WSH management continues to place major focus on assessing FTE utilization practices hospital-wide to ensure the most effective and efficient usage of each FTE. | • WSH Personnel Manager continues to work with accountability center directors analyzing organizational chart as needed with each Accountability Center Director to ensure each FTE is being utilized to its fullest potential and most appropriate placement. This will allow better, more efficient use of current job classes and provide appropriate expertise in behavior management and clinical care in the highest risk areas.<br>**Target: December 2002** |
| | • An IOP group is reviewing options to overtime use when staffing is not adequate. It is recommended that a "float pool" be considered that may decrease expenditures while making more adequate staffing | • Budget constrictions have not allowed development of a float pool as yet. The IOP group will continue to explore alternatives and offer recommendations and provide cost analyses to the Executive Management team regarding a float pool vs. overtime |

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| | readily available.<br><br>• The WSH Security Department assessment of staffing concluded that increased security presence on campus would be beneficial. Increase in workload continues due to enhanced reporting protocols, data tracking, alarm monitoring and incident follow-up protocols.<br><br>• Enhanced training (behavior intervention and management, crime scene preservation, police report writing, witness statements, evidence collection, etc.) and progressively increasing responsibilities warrant review of Security Officer classification to ensure equitable salary and decrease recruitment/retention difficulties. Position reclass may enable retention of more experienced security staff. | usage.<br>**Target: January 2003**<br><br>• The WSH Security Manager and Chief Operating Officer will conduct a semi-annual review of security staffing. Recommendations to increase staffing will be factored into budget forecasting.<br>**Target: Semi-annually in June/January**<br><br>• WSH Management to work with Human Resources and DOP to determine most appropriate security staff classification and take steps to facilitate change.<br>**Target: Currently assessing** |
| c. Personnel policies | • 90 percent of all policies identified in the assessment have been reviewed and completed. Sunset review dates will be monitored for completion by the WSH Policy Committee. In collaboration with labor unions and ESH, a Workplace Violence Policy was completed and incorporated into new employee hospital orientation curriculum. The WSH Policy Review Committee should continue to monitor these policies during their review process for ways to reduce workplace violence.<br><br>1.1.7 - Administrative Incident Reporting<br>1.2.5 – Hospital Ward Capacities<br>1.3.5 - Personal Identification Badges<br>1.9.1 – Hospital Safety (currently being updated, 5/2002)<br>1.9.4 – Possession and/or Use of Firearms, Weapons, and Explosives<br>1.9.5 – Smoking/Tobacco Products (September, WSH | • Updated and new policies will be made available to staff hospital-wide via Intranet with hard copy distribution and/or Staff Development Department training. The system for communication of new/changed policies is under review by Executive Management.<br>**Target: on-going** |

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| | to become non-smoking facility)<br>1.9.9 – Emergency Response to Fire, Earthquake or Other Disaster<br>1.9.10 – Alcohol and Drug-free Workplace<br>2.3.1 – Medical Emergencies (Code 4) currently being updated 5/2002<br>2.3.2 – Assuring Availability of Service by Qualified Personnel<br>2.4.1 – Seclusion & Restraint (updated every few months as standards change)<br>2.4.5 – Pat Down Searches<br>2.5.8 - Duty to Notify and Warn<br>2.6.5 – Patient Placement Review Team<br>2.6.6 – Review of Sentinel Event<br>3.1.1 – Employees' Rights and Responsibilities<br>3.2.9 – Management of Hospital Personnel Exposed to Blood or Other Potentially Infectious Materials<br>3.4.4 – Patient Abuse<br>3.4.10 – Workplace Violence<br>3.4.11 – Support for Staff who Experience Assault<br>3.5.2 - Transitional Return to Work<br>3.5.3 - Emergency Medical Services (currently being updated, 5/2002)<br>3.7.1 – Training<br><br>New – Workplace Violence | |
| d. First aid and emergency procedures | • A series of meetings with local fire and law enforcement officials have brought forth ideas that would enhance first responder efforts (see plan). WSH needs to continue efforts with police and fire officials to enhance response capabilities. Data input to the system has been slower than expected due to workload and limited resources, however, continues to progress steadily. | • Monthly meetings continue and response protocols are established. WSH continues to work with the Department of Emergency Management, local fire and law enforcement to become part of the Pierce Responder System. This is a pre-incident emergency response planning system that will enable fire and police to access pertinent and vital information (floor plans, contacts, tactical considerations, etc.) in the event of a disaster via a laptop computer carried in the first responder vehicles. Examples include earthquake, fire, riot, hostage |

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| | | situation, and violent attacks/shootings.<br>**Target: July 2002**<br><br>• Hard copy locator maps have been updated since the changes created by the earthquake and distributed to fire and police departments to help reduce response times to emergencies.<br>**Target: Completed** |
| | • Recommend enhanced membership and education for the Critical Incident Stress Management (CISM) team by adding peer support members from all areas and shifts. This function is now required by JCAHO in the Environment of Care Chapter of the CAMH, under the Emergency Management element. | • Included in the 2001 L&I Safe @ Work grant application, grant dollars for training 25-30 peer support CISM team members. Grant application has been submitted for 2002. However, status of acceptance is unknown at this time. Limited staff development dollars impinge upon the ability to continue training in this regard if grant dollars are not available. Alternate funding will be explored if grant application is denied.<br>**Target: July 2002** |
| | • Training re: ability to access emergency medication room keys needs to be added to the "Orientation to Duty" checklist. | • All wards were equipped with an emergency key for entry into the medication room during an emergency. All staff was trained in ways to access the key for emergencies only. Nursing Department will ensure this item is added to the "Orientation to Duty" checklist.<br>**Target: Completed** |
| | • Behavioral Management and Intervention Team (BMIT) reviewed its mission. They recommended its members begin to focus on mentoring co-workers, working towards culture change and a more 'hope and recovery' approach to patient care and behavior management, in addition to providing crisis response services and conducting monthly crisis drills on all WSH wards. WISHA Safe @ Work Grant dollars have been utilized to establish 30 trainers who have to date trained approximately 600 employees in extended crisis intervention techniques above the basic training. | • WISHA Safe @ Work Grant dollars will be pursued each year for four years in an attempt to continue to provide the money for training, and back-fill for staff to obtain training, in order to sustain an infrastructure to uphold the mentoring/training concept. **This grant was not renewed for FY 01-02.**<br>**Target: Labor and Industries (L&I) imposed deadline date annually for four years** |

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| | • Dedicated phone line for emergencies is now on all WSH wards. All staff are trained. Should be added to the new employee's "Orientation to Duty" checklist. | • Nursing Department will ensure that this item is placed on the "Orientation to Duty" checklist and reviewed with all new staff.<br>**Target: In place/ on-going** |
| e. Violent acts:<br>1. Reporting of violent acts<br>2. Taking appropriate action in response to violent acts<br>3. Follow-up procedures after violent acts | • On-ward training to all staff was provided in procedures for reporting incidents, taking appropriate action in response to violent acts and follow-up procedures were thoroughly reviewed for effectiveness by Quality Management staff. New employees will need to be informed through new employee orientation. | • Reporting incidents, taking appropriate action in response to an incident, and follow-up procedures have become part of the new employee orientation curriculum in Staff Development.<br>**Target: Completed. New employees are educated during initial orientation**<br><br>All violent acts (assaults and threats) are now being reported to WSH Security Department. Security officers have received specialized training from local law enforcement in efficient report writing, preservation of crime scene, gathering witness statements and obtaining evidence. Security will maintain communication with law enforcement and prosecutor's office, when appropriate, for possible prosecution of perpetrators of violent acts which result in serious injury.<br>**Target: Completed**<br><br>WSH Safety Committee will review necessary data monthly (gathered from AROIs, Security Incident Reports (SIRs), L&I claims and DSHS form 133 – Report of Employee's Personal Incident) to determine patterns and trends for risk management purposes.<br>**Target: Process in place for monthly review**<br><br>A "recording line" has been established in the Safety Office for anyone to report any unsafe practice, concern or issue. The Safety Officer will be responsible for immediate follow-up action. All staff have been informed of the availability of this line. New employees will be advised of the availability of the recording line during initial orientation.<br>**Target: Completed** |

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| | | Clinical follow-up involving potentially violent patients will be conducted by treatment teams in conjunction with the Clinical Director to include medication review/pharmacy consult, clinical senior staff review and possible relocation and alternate treatment model considerations.<br>**Target: Process in place**<br><br>A review committee has been established that meets daily to review incidents and recommend and monitor follow-up.<br>**Target: Process in place** |
| | • Communication/coordination enhancement is recommended among local law enforcement, prosecutors and WSH in terms of reporting and responding to assault/crisis situations. | • Through a series of meetings, WSH officials, Assistant Attorneys General (AAGs), prosecutors and local law enforcement have established a reporting and response protocol. Ongoing meetings are scheduled to ensure continuity of communication among agencies. The protocol will be reviewed biannually with all stakeholders.<br>**Target: July 2002** |
| | • Recommend development of a record (log) of all assaults and verbal threats to provide more efficient tracking of violent incidents and follow-up action. Recommend the log be maintained by the Security Department and available upon request for inspection by L&I officials for compliance. | • The WSH Security Department maintains a record (log) of assaults and threats. The log will be analyzed by the Safety Officer and Security Manager on a weekly basis to identify patterns/trends for risk management purposes. Workplace violence data is submitted to the Safety Committee monthly.<br>**Target: Completed (on-going)** |
| | • The WSH CISM team has been established and has received nationally-accredited CISM training. This team provides stress management and post traumatic stress assistance to any staff in need of it after becoming the victim of an assault or after witnessing a serious assault. The team has recommended that all supervisors be trained to identify need for this service in their subordinates after a crisis situation. It is also recommended that all supervisors be trained to | • All supervisors have received mandatory training by the CISM team to:<br>1. Be aware of the service and how to access it<br>2. Be sensitive to the needs of staff transitioning back into the workforce after a time-loss assault<br>**Target: Completed / on-going** |

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| | identify need for this service and to assist staff transitioning back into the workforce after a time-loss assault. | |
| f. Development of criteria for determining and reporting verbal threats | • It was determined that criteria for determining and reporting threats (and attempted physical assaults) should be approved by members of the Mental Health Division's Quality Steering Committee. For consistency throughout the state, all three facilities would adhere to those definitions and, therefore, collect data consistently. | • The following definitions were forwarded to the Safety Committee and Quality Management to incorporate into their databases:<br><br>A "threat" must 1) be communicated, 2) convey intent to do harm, and 3) come from a person who is able to carry out the threat.<br><br>"Attempted physical assault" is a physical assault that is interrupted or actively avoided.<br>**Target: Completed** |
| g. Employee education and training | • The assessment identified a need to develop curriculum for identifying and reporting violence in the workplace. This curriculum would be added to new employee orientation.<br><br>• Professional Assault Response Training (PART) is mandatory for all new employees prior to reporting for a ward-based assignment. All current employees' records were reviewed for compliance.<br><br>• Assessment determined that monthly behavior crisis drills would be beneficial for staff development on all wards/all shifts. Monthly drills have been conducted throughout the year. It is recommended that these | • The WSH Security Manager is providing training to all new employees in identifying and reporting violence in the workplace. This training will remain a consistent part of the curriculum for all new employees.<br>**Target: Completed - process in place**<br><br>• PART training is a mandatory requirement for all WSH employees who are hired into ward-based job classifications. PART training shall be accomplished prior to ward assignment. Staff Development has provided an enhanced training schedule to ensure all current employees in a ward-based job classification received training in PART. Personnel Department has established a procedure that ensures new hires in ward-based job classifications are scheduled to start work after their PART training requirement is met.<br>**Target: Completed (on-going)**<br><br>• An IOP group developed a drill policy and procedure and is responsible to ensure quarterly crisis response drills are conducted on all wards/all shifts. The Department of Nursing is responsible to monitor and review the drills for effectiveness and |

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| | drills be changed to quarterly. Drill protocols emphasize teamwork, communication and physical skills. Quarterly drill reports should be monitored and reviewed by Department of Nursing. | training needs.<br>**Target: Completed - process in place** |
| | • All incumbents of ward-based job classifications are required to receive annual update training in PART (Professional Assault Response Training). Currently this training is in video format. The video should be reviewed periodically by Staff Development and updated/modified as needed. Due to budget constraints, staffing needs on the wards, and the lack of ability to provide overtime funding for training, alternate update training formats are being considered. | • Nursing Department and Staff Development are developing an independent learning packet that shall be required of each ward-based employee to complete on an annual basis. A record of this training will be placed in the employee's individual education file. |
| | • Methods to enhance annual update training in PART are being reviewed by the IOP group. The group has recommended two hours per year for employees assigned to higher risk wards. The curriculum covers safety awareness and principals of patient de-escalation. The BMIT (Behavioral Management/Intervention Team) members are the recommended persons to receive additional training to become trainers/mentors on each ward. It is recommended that there ultimately be one team member on each ward/shift who will be the trainer for that ward and ensure all staff assigned to a higher risk receive two hours of specialized behavioral intervention and de-escalation training, in addition to the required annual update training requirement. | • Staff Development and the Nursing Department shall conduct a review of the current PART update training video and modify if necessary. This training video will then be considered as a required training tool for annual updates for staff who are non-ward–based.<br>• Selection and training of the BMIT members is completed. A schedule has been adopted and the infrastructure for ongoing annual update training in PART has begun. Currently, approximately 600 staff on higher risk wards have received update training. Update training will continue in this fashion as long as funding allows back-up staff during training.<br>**Target: Being funded by hospital as grant was not renewed.** |
| | • Purchase of padded shields as a behavior management/intervention tool was approved. Padded | • A group of Nursing staff provided training in the use of padded shields to staff on selected higher risk wards. The BMIT group is |

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| | shields were made available to all wards and security officers. Specialized training was needed for staff to ensure safe usage. | planning to standardize methods and provide ongoing training in those unit areas where the devices are used.<br>**Target: Completed and on-going** |
| h. Clinical and patient policies and procedures in-cluding those related to:<br>1. Smoking<br>2. Activity, leisure and therapeutic programs<br>3. Communication between shifts<br>4. Restraint and seclusion | • The new CFS building is smoke-free. CFS management has researched the effects that a smoke-free environment can have on violent behaviors in an institutional setting. | • Research has led to the conclusion that a smoke-free environment can reduce violence in an institutional setting. Upon the opening of the new CFS building, it will be, **no smoking allowed anywhere within that facility**. Staff and patients are being offered alternatives to smoking and encouraged to quit or reduce the numbers of cigarettes they smoke prior to the move. Smoking cessation programs are offered to patients hospital-wide. The entire hospital is scheduled to become a non-smoking facility in September.<br>**Target: January 2002 for new CFS and campus wide on September 1, 2002** |
| | • Clinicians suggest that unstructured time leads to more violent incidents. Recommend enhanced programming for patients hospital-wide. | • All units have increased therapeutic and leisure activities to cover weekends and evenings. Unions/Management continue to collaborate to re-structure staff schedules to accommodate the increased and enhanced programming schedule.<br>**Target: Completed** |
| | • An IOP group has been assigned to research and recommend improvement for communication between shifts. | • The IOP group continues to explore and recommend improvement to communication among shifts, placing emphasis on ward "report" to fully discuss individual patients and their activities during the preceding shift relating to possible assault behavior. Nursing managers have completed organized visits to shift- change report meetings and are in the process of compiling those results. Recommendations will be brought forth to the Patient Care Committee for approval and implementation.<br>**Target: Completed and on-going** |
| | • WSH Policy 2.4.1 Restraint/Seclusion is under review by the Quality Management and Patient Care Committee for update to meet new JCAHO standards. | • WSH policy Policy 2.4.1 has been revised and submitted to WSH medical staff and the Governing Body for approval. Hospital-wide distribution of new policy is complete.<br>**Target: Completed** |

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| | • WSH is placing major focus on taking steps to significantly reduce the use of seclusion and restraint. Hospital management is attempting to promote a culture change which will encourage a more humane approach to patient care. This approach promotes hope and recovery and earlier intervention in behavior management and de-escalation techniques. This will ultimately result in a significant decrease in violent behaviors, and reduce restraint/seclusion usage. | • Ongoing efforts continue through Management, Staff Development and the BMIT team to promote an overall culture change towards a more humane approach to patient care and earlier intervention in behavior management and de-escalation techniques.<br>**Target: On-going** |
| Analysis of data on violence and workers compensation claims during at least the preceding year | • L&I provides semi-annual analysis of the L&I claims information.<br>• Monthly analysis of WSH L&I claims data for review submitted by WSH Safety/Claims to Safety Committee Chairman.<br>• WSH QM provides trend data quarterly to the Safety Committee.<br>• The Quality Steering Committee of the MHD approved definitions on "verbal threats" and "attempted physical assaults" to be used throughout the state to ensure databases remain consistent.<br>• Data analysis has indicated that violence increases as patient census peaks. Increased community/Regional Support Network (RSN) involvement to assist in leveling census or to assist during census spikes is suggested. | • WSH Executive Management and Safety Committee will review L&I claims information semi-annually.<br>• Monthly analysis of L&I claims data will continue at WSH Safety Committee based on input from WSH Claims Section.<br>• Trend data from QM will continue to be analyzed quarterly by the Safety Committee.<br>• WSH staff has been educated about the inclusion of these new definitions and process of reporting. New fields will be incorporated into existing databases for data collection purposes. Manual data collection processes are in place in the interim.<br>**Target: Completed - processes in place**<br>• WSH management will continue to involve RSNs in planning efforts to control census at the hospital. |
| Input from staff and patients such as surveys and information relevant to the lettered elements above. | • WSH employee questionnaire was distributed hospital-wide with a 30 percent response. Surveys should be conducted annually and results analyzed by the Safety Committee. | • All employees will receive a voluntary employee questionnaire on an annual basis to determine employee perceptions and concerns. The questionnaire will follow the guidelines of L&I, with special focus on violence in the workplace. The WSH Safety Committee will analyze survey results annually. Results |

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| | | and recommendations from the Safety Committee will be submitted to hospital management for follow-up.<br>**Target: Annually in October** |
| | • Bi-weekly patient forums are conducted where it has been determined that this should be used as an avenue for patients to voice concerns regarding their safety. These meetings will also be used as an avenue to educate patients about violence and its effect on the hospital, staff and other patients. The WSH patient ombudsman will follow-up issues with hospital management. | • Safety/Risk Management staff and Safety Committee will conduct a monthly review of patient forum meeting minutes for pertinent information and work with the WSH patient ombudsman to initiate follow-up when needed.<br>**Target: Completed - process in place** |
| | • An annual patient satisfaction questionnaire is conducted through the University of Washington Research Institute. | • The WSH Quality Council analyzes the results of this study annually. Recommendations for improvement are forwarded to the WSH management team.<br>**Target: Annually in October**<br>. |
| Review of guidelines on violence in the workplace or state hospital issued by Department of Health (DOH), DSHS, L&I, Occupational Safety and Health Administration (OSHA), Medicare, others | • The Safety/Risk Management Office reviews and implements these guidelines and has frequent consultation with the DSHS Office of Risk Management (ORM). | • Safety/Risk Management Office will continue to be updated on DOH, DSHS, L&I, JCAHO and CMS guidelines and utilize them in planning workplace violence prevention at WSH**.**<br>**Target: Completed / on-going** |
| Violence prevention training with consideration to 14 topics in the law | • Prior to an assignment to hands-on patient care, all employees must receive PART. This training will cover, but is not limited to, the following:<br>1. General safety procedures<br>2. Personal safety procedures and equipment<br>3. The violence escalation cycle<br>4. Violence predicting factors<br>5. Obtaining patient history for patients with violent behavior or a history of violent acts<br>6. Verbal and physical techniques to de-escalate and minimize violent behavior<br>7. Strategies to avoid physical harm | • WSH Staff Development provides mandatory orientation training for all new employees that covers all areas listed in the assessment. Staff assigned to clinical positions receive a two-week orientation, while support staff receive the one-week version. All ward-based staff must attend this training prior to being assigned to duty. Other non-ward-based staff must receive the training within 60 days of hire. Further, a training brochure will be prepared and distributed by Staff Development which covers the 14 training topics for existing staff who received orientation prior to the implementation of the workplace safety for hospitals legislation passed in 2000.<br>**Target: July 1, 2002 – process is currently in place** |

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| | 8. Restraining techniques<br>9. Documenting and reporting incidents<br>10. Debriefing of violent act<br>11. Resources available to employees for coping with violence (CISM Team)<br>12. WSH's workplace violence prevention plan and policy<br>13. Use of inter-shift reporting process to identify high-risk patients<br>14. Use of the multidisciplinary treatment process and/or ways to communicate treatment plans and violence prevention strategies to all staff on the ward<br><br>• The WSH Safety Office has taught an overview of workplace and domestic violence in the new employee orientation for more than two years. Staff Development devised an information flyer on domestic violence in the workplace that will be distributed to all WSH staff.<br><br>• Staff Development and the Safety Office have devised a new briefing on domestic violence in the workplace. Training objectives are to raise awareness, improve identification of domestic violence in the workplace and suggest resources for victims and supervisors. | • The domestic violence pamphlet has been distributed to all WSH staff as a paycheck insert and is given to all new employees at their New Employee Orientation safety training sessions.<br>**Target: Completed / on-going**<br><br>• The new curriculum for domestic violence is included in new employee orientation curriculum taught by the Safety Officer.<br>**Target: Completed /on-going** |
| Record of violent acts including physical assault or "attempted" physical assault | • A procedure for centralized recording of all violent acts needs to be developed. The log will need to be made available upon request for inspection by WISHA (L&I) Compliance Officers. Data on assaults has been gathered for over 10 years. Quarterly trends have been presented to Quality Council and Governing Body. There are elements of the law not presently collected in the current data collection | • The Threat and Assault Log, a collection of Security Incident Reports(SIRs), is the responsibility of the WSH Security Manager and is a working document ready for inspection.<br>**Target: Completed - process in place**<br><br>• WSH Quality Council and Governing Body receive quarterly trends from L&I to utilize as a risk management tool and use as an indicator to measure success of the Workplace Safety |

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| | fields<br><br>• Recorded information will include all of the Following:<br>1. A full description of the violent act<br>2. When the violent act occurred<br>3. Where the violent act occurred<br>4. To whom the violent act occurred<br>5. Who perpetrated the violent act<br>6. The nature and severity of the injury<br>7. Weapons used<br>8. Number of witnesses (and names)<br>9. Action taken | Plan.<br>**Target: Completed - process in place**<br><br>• AROIs will be filed on all violent acts and submitted to Quality Management Department for data entry, analysis, and identification of patterns and trending. Other records will be used in analysis process and data collection, including DSHS form 133 - Report of Employee Personal Incident.<br>**Target: Completed - process in place**<br><br>• All information required by law is being collected and will be retained no fewer than five years to utilize in analysis of assault and injury due to assault.<br>**Target: Completed – process in place** |

# Appendix B - Workplace Safety Plan (ESH)

## Eastern State Hospital

**UPDATE**
**July, 2002**

RCW 72.23.400 requires each state hospital (WSH, ESH, CSTC) to develop a plan to reasonably prevent and protect employees from violence at the state hospital. The law requires completion of a security and safety assessment to identify existing or potential hazards for violence in the workplace. Using the results of the assessment, each state hospital must develop a plan to reasonably prevent and protect employees from violence. The following table lists the elements of both the assessment and the plan as required by law. It then provides a summary of the results of the assessment as well as the plan derived from that assessment.

** **UNDERLINED ITEMS ARE CURRENT ADDITIONS TO THIS PLAN.**

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| e) The physical attributes of the state hospital including:<br>1. access control<br>2. egress control<br>3. door locks<br>4. lighting<br>5. alarm systems | 1) Access control<br>a) Open campus/ location (rural), multiple buildings & locations (multiple areas isolated after dark). Problem identified with Security staffing (one per shift, hospital-wide). Security staff are providing back-up to Switchboard, which increases problems with response and coverage by Security. | 1) Access Control<br>a) Increase Security staffing to two per shift to provide back up.<br>**Security staffing duties have been reconfigured so that Security staff (currently one per shift) are not required to relieve Switchboard except as follows:**<br>**7-3 shift: During severe staff shortages**<br>**3-11 shift: Sunday only**<br>**11-7 shift: Seven days per week**<br>**Previously Security staff provided relief seven days per week for all three shifts. This reconfiguration has resulted in increased hours that Security staff is able to respond. There is no funding or authorization to increase full-time employees at this time.**<br>**COMPLETED** |

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| | b) Current system for monitoring visitor access to and exit from the Eastern State Hospital campus and buildings is inadequate. Approximately 25 visitors per day visit the Eastlake and Westlake buildings. | b) Provide time-sensitive visitor badges or badges with expiration dates.<br>**COMPLETED**<br><br>Updated Visitor Policy procedures have been approved and implemented.<br>**Improved signage installed next to Switchboards indicating visitor policy regarding wearing and returning of badges.**<br>**COMPLETED** |
| | c) There are occurrences of stolen, misplaced, lost or not turned in employee cards and/or keys assigned to individual employees. | c) Increase awareness to supervisors and employees regarding their responsibility for timely reporting of lost cards and keys through new employee/supervisor safety and annual refresher training.<br>**New Employee Orientation: COMPLETED**<br>**Supervisor Safety Training: 8/7/02**<br>**Annual Fire/Safety/HAZCOM and Security Training**<br>**Eastern State Hospital is currently transitioning from a self-paced, informational board system to a classroom setting using a PowerPoint presentation, which will incorporate this information – 8/7/02**<br>**COMPLETED**<br><br>**All listed training is ongoing, mandatory and scheduled monthly**. |

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| | d) Westlake Building exterior doors do not always remain locked (not all are self-locking). | • Develop a tracking system for the return of keys/cards from employees when transferred to other areas/departments.<br>**A new system was presented to the Executive Committee on October 3, 2000 and was approved and implemented on November 7, 2000. COMPLETED**<br><br>d) Identify exterior doors that do not close properly and place work orders to repair or replace.<br>**Ongoing - weekly environmental surveys (worksite inspections). Westlake patio doors are particularly problematic and latest information from Capital Programs indicates these are high on the priority list for replacement. Funded, but still waiting to go out for bid.**<br><br>Identify high-risk exterior doors that do not have self-locking mechanisms and place work order for lock replacement.<br>**An assessment of feasibility for replacement of all identified locks with snap locks was completed by Consolidated Support Services as well as a complete estimate of materials and labor cost for this replacement. Upon further evaluation with input from the Forensic Services Unit, it has been identified that installation of self-locking mechanisms would increase elopement risk and alternative locking mechanisms would compromise safety in other regards.** |

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| | e) There are increased potential hazards with walk-in admissions. | e) Review and revise current policy for walk-in admissions to address safety/security issues of both staff and patients. Performance Improvement Team (PIT) currently in place. **Increased staff presence is occurring. A policy & procedure review has been completed and recommendations to conduct these interviews in a less isolated location were presented to and approved by the ESH Interdisciplinary Treatment Committee and will be implemented May, 2001. COMPLETED** |
| | f) Increased potential hazards for violence in areas due to open access during business hours:<br>- Switchboard (Eastlake and Westlake buildings)<br>- Patient Accounts<br>- Personnel<br>- Pharmacy<br>- Central Nursing Office<br>- Medical Records | f) Eastlake Switchboard should remain locked at all times. **On October 3, 2000, policy was presented to the Executive Committee and was approved and implemented. COMPLETED**<br><br>Patient Accounts should remain locked at all times. **On October 3, 2000, policy was presented to the Executive Committee and was approved and implemented. – COMPLETED** |

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| | | • Increase awareness of potential for violence and appropriate actions to be taken through training.<br><br>**Safe & Therapeutic Aggression, Assault Reduction Training (S.T.A.A.R.T.) has been ongoing since 1996. This information has also been presented in New Employee Orientation since January, 2000. COMPLETED**<br><br>**Eastern State Hospital is currently transitioning from a self-paced, informational board system to a classroom setting for both supervisor safety and annual safety refresher training using a PowerPoint presentation, which will incorporate this information – June 1, 2001. All listed training is mandatory. COMPLETED**<br><br>**Training developed by ESH staff and funded by the WISHA Grant Program for direct-care staff in identified high-risk areas was completed June 30, 2001. The goal is to prevent incidents of violence and reduce injuries to employees in state psychiatric hospitals. The majority of grant dollars were utilized for backfill coverage costs for those being trained. Training was scheduled to continue in September, 2001 with the direct-care staff on remaining wards as well as Food Service, Rehabilitation Services and Social Work staff. Due to the lack of Grant** |

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| | | **Program funding, this training will not be occurring.**<br><br>**In addition, a videotape of a workplace violence drill conducted at ESH will be incorporated into current training offerings.**<br>**COMPLETED** |
| | 2) Egress Control<br>a) No physical control over egress (visitor/staff) on campus. Remedy would essentially require a security fence around entire perimeter of | • A work order is in place to install a pharmacy duress alarm and will be tested to ensure proper function/ relay to the Eastlake Building Switchboard and disconnected from all ward annunciation panels.<br>**The intrusion alarm currently in place has been modified to allow Pharmacy staff to send an alarm directly to the Switchboard, bypassing wards.**<br>**COMPLETED - Tested March, 2001**<br><br>• Development of pharmacy duress alarm procedures.<br>**Interim procedure in place**<br>**COMPLETED**<br><br>• Increase awareness of potentials for violence and appropriate actions to be taken through training.<br>**Refer to Pages 4 & 5**<br>2) Egress Control<br>a) **Security personnel log daily activity and report trends monthly & quarterly to the Safety Committee**. |

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| | hospital and this is not consistent with hospital mission, vision, or values.<br>b) Visitor policy and procedure. Badges not always turned in by visitor.<br>c) Potential for violence when apprehending patients that have gone on unauthorized leave. | b) **COMPLETED**<br>Refer to Page 2<br>c) Increase Security staffing.<br>**Refer to Element "b", Page 1** |
| | 3) Door Locks<br>a) Current employee key control and tracking system with regard to change of employee need/status is inadequate.<br>b) Individual staff do not have keys/reader cards for all areas of hospital, which may reduce response time during emergencies.<br>4) Outside Lighting<br>a) Burned out/malfunctioning outside lighting.<br>b) Amount of time for replacement. | 3) Door Locks<br>a) Develop key possession tracking system with regard to change of employee need/status. Update current key control policy to reflect need to re-assess keys issued to employees when area of assignment changes.<br>**Refer to Access Control**<br>b) Develop policy and procedure to address emergency response in light of this issue.<br>**COMPLETED**<br>4) Outside Lighting<br>a/b) Request monthly report from Consolidated Support Services regarding the submission of campus lighting work orders and completion dates.<br>**COMPLETED – there is currently a procedure in place. The Electric Shop gives all lighting work orders a priority based on overall lighting requests/needs.**<br>**Forensic Services Unit perimeter lighting has been increased and is immediately replaced when not working.** |

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| | 5) Alarm System<br>a) No duress alarms in south end Eastlake Building basement. | 5) Alarm System<br>a) Access to the basement has been limited to staff only by locking all exterior access doors eliminating the need for installation of alarm. **COMPLETED** |
| | b) Individual staff do not have keys/card to operate duress system in all areas of the hospital.<br>Housekeeping<br>Food Service<br><br>c) Subject to malfunction and accidental activation.<br><br>d) Radios - low/dead battery | b) Issue duress alarm key to all staff.<br>**Staff will be issued keys and receive training regarding use duress alarm system – June 1, 2001.**<br>**COMPLETED**<br><br>c) Develop hospital policy and procedure for testing of duress alarm system.<br>**The duress alarm is currently tested daily on all wards by ward staff (APU & FSU).**<br>**COMPLETED**<br><br>d) Increase training on use and maintenance of radio equipment.<br>**Initial training is provided by the ESH Safety Officer and Security personnel. Annual competency of staff in the use and maintenance of radio equipment will be evaluated by supervisors utilizing a Criteria Based Performance Evaluation Tool (CBPET) COMPLETED** |

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| | e) Limited initial and ongoing training for all staff regarding types and use of alarm systems and radio.<br><br>f) No duress alarms in patient dining rooms (Westlake Building, Eastlake Building, Campus Inn).<br><br>g) No duress alarm in FSU administration office. | e) Increase training on use and maintenance of radio equipment.<br>**COMPLETED – stated above**<br><br>f) Installation of alarms in these areas<br>**Patients are escorted by staff to dining areas during meal times. Staff are equipped with portable radios for communication. Duress alarm system not indicated at this time. – COMPLETED**<br><br>g) Installation of alarms in this area.<br>**Access to this area is limited and communication capabilities increased via portable radios. Duress alarm system not indicated at this time. – COMPLETED** |
| b) Staffing, including security staffing | 1) With only one Security staff member on duty at any given time, there is strong potential for an act of violence to overwhelm the Security staff's ability to contain or control it. This could subject the Security staff to injury and jeopardize others before local law enforcement could respond to provide assistance. | 1) Consider an increase in Security department staffing to provide coverage as follows.<br>a. 7:00am - 3:00pm – 7 days per week.<br>b. 3:00pm - 11:00pm – 7 days per week.<br>c. 11:00pm - 7:00am – 7 days per week.<br>d. 12:00pm - 8:00pm – 7 days per week.<br>e. 8:00pm - 4:00pm – 7 days per week.<br>**There is no authorization or funding to increase full-time employees at this time.**<br><br>• Eliminate the use of Security staff to relieve hospital Switchboards, which make them unavailable for response to security or other emergency situations.<br>COMPLETED - See Access Control, Page |

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| | 2) Authorize Security Staff to carry non-lethal chemical spray for self-protection and as a last-resort measure to prevent violent acts against others perpetrated by employees or visitors. (chemical spray would not be authorized for use on patients). | 2) Initial authorization has been provided by the Eastern State Hospital Executive Committee. This measure will require discussion with the Mental Health Division Director and authorization at that level. This will be presented to the Eastern State Hospital Governing Body Subcommittee on May 23, 2001.<br><br>It was the decision of the ESH Executive Committee, after consultation with the Attorney General's office, that authorizing Security staff to carry non-lethal chemical pray is not a viable safety measure. **COMPLETED** |
| | 3) Systems for identifying variances in staffing and responding to these in a timely manner are in place and appear to be adequate in general.<br>Additional tools/systems used in nursing include<br>- policy/procedure on how to acquire staff<br>- acuity based staffing plan<br>- guidelines for safe staffing levels | 3) No additional actions required |
| c) Personnel policies | 1) Though the Eastern State Hospital (ESH) Policy 1.41 is part of the new employee training, it could be expanded to give a more complete overview of the workplace violence policy. | 1) ESH Workplace Violence Policy should be given more attention in new employee training, annual refresher and supervisor safety training<br>**New Employee Orientation: Implemented & ongoing since January, 2000 – COMPLETED**<br>**Eastern State Hospital is currently transitioning from a self-paced, informational** |

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| | | **board system to a classroom setting using a** |

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| | | **PowerPoint presentation for both Supervisor Safety and annual safety refresher training, which will incorporate this information – June 1, 2001. All listed training is mandatory. COMPLETED** |
| | 2) Because the Department of Social and Health Services (DSHS) Administrative Policy 6.20 is not part of the new employee and supervisor safety training, employees are unaware of its contents. | 2) DSHS Administrative Policy 6.20 should also be part of the new employee, annual refresher and supervisor safety training. **The new ESH Workplace Violence Policy incorporates the DSHS Administrative Policy 6.20 and has been implemented. Training will be incorporated and implemented as stated above.** See training listed on page 2 |
| d. First aid and emergency procedures | 1) There are hospital staff that are sometimes off campus and may need to administer first aid in the event of a violent act or accident. Because the employees that conduct these activities are not medical or nursing staff, they may need to be trained in first aid. | 1) ESH employees that are not medical or licensed nursing staff but are still involved in one to one or group patient activities (i.e. Rehab Services) should have first aid training. **Nursing staff have been identified as a priority under the Emergency Management Plan update with RN's & LPN's trained first – October, 2002**<br><br>**Rehabilitation Services' staff trained – COMPLETE.** |
| e. Violent acts:<br>• Reporting of violent acts<br>• Taking appropriate action in response to violent acts<br>• Follow-up procedures after | 1) Difficulty in getting staff to refresher training (lack of coverage). | 1) Additional position for Safe and Therapeutic Aggression/Assault Reduction training. A trainer, obtained through seclusion and restraint supplemental funds, will be doing intensive on-ward training. **COMPLETED – additional RN** |

| | | |
|---|---|---|
| violent acts | | **position filled on June 19, 2000.** |

| **Elements of the plan per law**. (Items a through h below are part of the security & safety assessment) | **Assessment** – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence. | **Plan** – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence. |
|---|---|---|
| | 2) All elements under this area appear to be currently covered and systems are working well. Policies/procedures have generally been implemented as directed. One exception is the ESH Workplace Violence Policy, which is a new policy/procedure and implementation thus far has been inconsistent. This is an area targeted by the Safety Committee for improvement.<br><br>3) All elements pertaining to follow-up procedures appear to be covered and systems are working well. | 2) Safety Committee is focusing on review of implementation of ESH Workplace Violence Policy and identification of revisions needed. **COMPLETED**<br><br>3) Maintain follow-up procedures |
| f. Development of criteria for determining and reporting verbal threats | 1) ESH has been using criteria as identified in the MHD Quality Steering Committee definition for assault in the Unusual Occurrence Reporting System (UORS) for the past 10 years. However, criteria/definition for verbal threat will also need to be included and this will require staff inservice and training. | 1) Verbal threat criteria/definition **COMPLETED: August 2000**<br><br>Staff inservice and training **COMPLETED – October 2000 and pilot (consistent with WSH and CSTC) for reporting has been implemented** |
| g. Employee education and training | 1) Not all new employees receive new employee orientation including the Safe and Therapeutic Aggression/Assault Reduction (STAART) training class in a timely manner. Some are employed at ESH for months before receiving this training. | 1) All new employees receive new employee orientation within the first month of employment. **Current tracking system is in place to monitor compliance. COMPLETED** |

| **Elements of the plan per law**. (Items a through h below are part of the security & safety assessment) | **Assessment** – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence. | **Plan** – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence. |
|---|---|---|
| | 2) Not all-current employees are required to take STAART initially or updates after the initial education in new employee orientation. | 2) All current employees are required to take the initial 8-hour STAART and 4-hour updates every two years. **COMPLETED** |
| | 3) Need an update class for current staff that incorporates the Violence in the Workplace Policy #1.41 and other aspects of this plan. This should be a mandatory class with updates annually that incorporate changes in the overall security plan. | 3) Develop a mandatory update class for current staff that incorporates the Violence in the Workplace Policy #1.41 and other aspects of this Workplace Safety Plan that staff are not currently aware of. Updates would be required annually.<br>**Refer to training – Page 5**<br><br>**Ongoing training courses are under development**.<br><br>**Training curriculum developed for the L&I Grant also addresses many of these issues with identified high-risk, clinical areas.**<br><br>**Training was scheduled to continue in September, 2001 with the direct-care staff on remaining wards as well as Food Service, Rehabilitation Services and Social Work staff. Due to the lack of Grant Program funding, this training will not be occurring.** |

| **Elements of the plan per law**. (Items a through h below are part of the security & safety assessment) | **Assessment** – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence. | **Plan** – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence. |
|---|---|---|
| | 4) Need more education in conflict management and classes in anger management, stress management and dealing with change in a positive manner. | 4) Offer training in conflict management, stress management, anger management and dealing with change in a positive manner to ESH employees. Education to include various methods of instruction including classes, workbooks and videos.<br>**Inservices encompassing interpersonal communication skills in a hospital setting, sexual harassment and workplace violence (non-clinical staff initially):**<br>**April/May, 2001 (This is included in the above training).**<br><br>**Ongoing training courses are under development**. |
| h) Clinical and patient policies and procedures including those related to:<br>• Smoking<br>• Activity, leisure, and therapeutic programs<br>• Communication between shifts<br>• Restraint and seclusion | 1) Limited Rehabilitation Services provided to patients may result in increased patient agitation due to limited activity, leisure and therapeutic programming. | 1) Increase Rehabilitation Services staffing<br>**Five additional positions for Rehabilitation Services have been obtained through seclusion and restraint supplemental funds. Three of these positions are specific to increasing evening and weekend programming.** |

| **Elements of the plan per law**. (Items a through h below are part of the security & safety assessment) | **Assessment** – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence. | **Plan** – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence. |
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| | | • Review data related to patient behavioral problem times, areas, etc., to identify increased needs for structured treatment programming.<br>**All five positions were filled. There is currently an occupational therapist vacancy. A research proposal (evaluation of an ESH Geropsychiatric Quality Improvement Initiative) has been submitted to evaluate the effect of providing regular access to the outdoors on the Geropsychiatric Unit (GPU) to decrease agitation and use of seclusion/ restraint. COMPLETED**<br>• Revise program scheduling to increase use of therapy pool/aquatic therapy.<br>**Implemented and ongoing**<br>• Research vocational opportunities/resources for patients.<br>**The Occupational Therapy Prework Group was created as a collaborative multidisciplinary approach to develop basic cognitive, social and pragmatic prework skills with patients from the Adult Psychiatric Unit. Pilot Project: October 23, 2000 to December, 2000. There is a current vacancy and recruiting is in progress for this position. Current, ongoing work readiness activities are in place.** |

| **Elements of the plan per law**. (Items a through h below are part of the security & safety assessment) | **Assessment** – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence. | **Plan** – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence. |
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| | 2) Lack of communication between recreation therapy and recreation specialist disciplines. | 2) Standardize communication forms to increase communication between disciplines.<br>**A draft form was developed and piloted. This form was reviewed on November 1, 2000 and is currently utilized.**<br>**COMPLETED** |
| | 3) Trends have been identified which show increased patient agitation due to hearing deficits. | 3) Increase communication with attending physicians and other referral resources to increase referrals for audiology services especially on the GPU.<br>**Meetings are scheduled with the physicians and/or program directors on a regular basis to increase communication and education regarding audiology services.**<br>**COMPLETED** |
| | 4) High admissions with low Rehab staff to patient ratio. | 4) Increase Rehabilitation Services staffing.<br>**Five additional positions for Rehabilitation Services have been obtained through seclusion and restraint supplemental funds. Three of these positions are specific to increasing evening and weekend programming. One position is specific to patient vocational opportunities and one is targeted for clinical direction and competency evaluation for recreation therapy staff.** |

| **Elements of the plan per law**. (Items a through h below are part of the security & safety assessment) | **Assessment** – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence. | **Plan** – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence. |
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| | 5) Increased patient agitation upon admission has been evaluated. | 5) Recommend that attending physicians be more aggressive with initial medications to cover increased patient agitation at admission.<br>**Presented to Medical Executive Committee for review on October 4, 2000**<br>**Physicians agreed to evaluate each situation on a case-by-case basis with safety as the highest priority.**<br>**COMPLETED** |
| | 6) Limited adaptive equipment to increase patient mobility and decrease use of restraints. | 6) Provide additional adaptive equipment to increase patient mobility and decrease use of restraints.<br>- Hi-Low Beds<br>- Mattresses (floor mats)<br>- Ultimate Walkers<br>**Improving Organizational Performance Team currently reviewing fall protocol to include identifying need for additional adaptive equipment.**<br><br>**Some of the equipment needs identified by this team include:**<br>• **12 Broda Chairs ($3,000 ea)**<br>• **100 Hi-Low Beds ($2,000 ea)**<br>**Total costs for equipment needs are estimated at approximately $75,000. There are approximately 13 Broda Chairs, seven ultimate walkers and 40 hi-low beds already purchased and in place. Funding is not available at this time for further purchases.** |

| **Elements of the plan per law**. (Items a through h below are part of the security & safety assessment) | **Assessment** – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence. | **Plan** – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence. |
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| | | **Maintenance/repair work was identified by this team to include replacement of carpet with vinyl (infection control & trip hazard) at an approximate cost of $50,000 per ward. Replacement of vinyl on GPU wards is to be completed May, 2002 - COMPLETED Funding permits 80%-90% replacement. Alternative funding sources are being researched.** |
| | 7) Placing patients in seclusion/restraint increases potential for employee injury. | 7) Increase staff training in use of less-restrictive alternatives.<br>**Additional videotapes have been purchased. New employee orientation content expanded. COMPLETED.**<br>**Revisions are being made to the seclusion and restraint procedures. Inservices will be completed on application and use of restraints as well as less-restrictive alternatives. Significant reductions in seclusion/restraint use have been noted. COMPLETED** |
| | 8) Non-therapeutic interactions with patients increases the potential for employee injury. | 8) Consistent supervision & corrective action to ensure therapeutic interactions.<br>**Currently, ESH has completed development of additional training funded by the WISHA Grant Program. The goal is to prevent incidents of violence in state psychiatric hospitals. Training for direct-care staff in identified high-risk areas is targeted to begin May 1, 2001.** |

| **Elements of the plan per law**. (Items a through h below are part of the security & safety assessment) | **Assessment** – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence. | **Plan** – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence. |
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| | | **Training developed by ESH staff and funded by the WISHA Grant Program for direct-care staff in identified high-risk areas was completed June 30, 2001. The goal is to prevent incidents of violence and reduce injuries to employees in state psychiatric hospitals. The majority of grant dollars were utilized for backfill coverage costs for those being trained. Training was scheduled to continue in September, 2001 with the direct-care staff on remaining wards as well as Food Service, Rehabilitation Services and Social Work staff. Due to the lack of Grant Program funding, this training will not be occurring.** |
| i) Analysis of data on violence and workers compensation claims during at least the preceding year | 1) These records are on a database and are analyzed and trended at least quarterly.<br><br>2) ESH has been using criteria as identified in the MHD Quality Steering Committee definition for assault in the UORS for the past 10 years. However, criteria/definition for verbal threat/ attempted physical assault will also need to be included and this will require staff inservice and training. | 1) Verbal threat criteria/definition **COMPLETED – October, 2000, pilot (consistent with WSH and CSTC) for reporting has been implemented**<br><br>2) Staff inservice and training. **COMPLETED – October 1, 2000 and pilot for reporting has been implemented and incorporated into current system. Ongoing training will be integrated into current training – see Page 5. <u>COMPLETED</u>**<br><br>• Continue current reporting, trending and analysis. |

| **Elements of the plan per law**. (Items a through h below are part of the security & safety assessment) | **Assessment** – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence. | **Plan** – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence. |
|---|---|---|
| j) Input from staff and patients such as surveys and info relevant to the lettered elements above. | 1) The Complaint Review Team has identified that trending of the nature of the complaints is an area that requires improvement. | 1) The Complaint Review Team is meeting bi-monthly to identify how to capture trends that would inform and be of benefit to ESH.<br>**The Complaint Review Team meets bi-monthly to review trends. Aggregate data on trends is being developed for ward/unit management groups to make appropriate program changes.** |
| | 2) There is no survey that specifically addresses violence in the work place in any of our hospital training procedures. | 2) Survey issued to all employees. Results will be reviewed with the results incorporated into the plan. The hospital needs a specific violence in the workplace training program and a method of employee feedback.<br>**Refer to Page 5** |
| | 3) The Unusual Occurrence Reporting System is currently part of the new employee orientation and nursing services training. | 3) Eastern State Hospital's Unusual Occurrence Reporting System needs to remain an important part of the hospital training program with more emphasis on what constitutes an unusual occurrence.<br>**A function of one of the new positions entails reviewing unusual occurrence reports for completeness and accuracy and review of all occurrences of seclusion/restraint** |
| | 4) The hazard report program is not used consistently by the employees to identify safety hazards. | 4) The hospital needs to provide more specific training for the employees in the area of safety hazard reporting.<br>**There has been an increased focus in training and it is evident (by the volume of reporting) that this has been effective.** |

| **Elements of the plan per law**. (Items a through h below are part of the security & safety assessment) | **Assessment** – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence. | **Plan** – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence. |
|---|---|---|
| k) Review of guidelines on violence in the workplace or state hospital issued by DOH, DSHS, L&I, OSHA, Medicare, others. (Not required) | 1) Utilize as resource | 1) Reports to the Safety Committee routinely include updates on all pertinent guidelines and these are utilized in planning workplace violence prevention at ESH. |
| l) Violence prevention training with consideration to 14 topics in the law | 1) Must be addressed in the plan. | 1) In-services encompassing interpersonal communication skills in a hospital setting, sexual harassment and workplace violence (non-clinical staff initially)<br>**COMPLETED** |
| | | **Eastern State Hospital is currently transitioning from a self-paced, informational board system to a classroom setting using a PowerPoint presentation, which will incorporate this information – June 1, 2001.** |
| m) Record of violent acts including physical assault or "attempted" physical assault | 1) These records are on a database and are analyzed and trended at least quarterly.<br><br>2) ESH has been using criteria as identified in the MHD Quality Steering Committee definition for assault in the UORS for the past 10 years. However, criteria/definition for verbal threat attempted physical assault will also need to be included and this will require staff inservice and training.<br><br>3) Continue current reporting, trending and analysis**.** | 1) Verbal threat criteria/definition<br>COMPLETED<br><br>2) Staff inservice and training.<br>COMPLETED<br><br>3) A pilot for reporting will be implemented and incorporated into the current system.<br>COMPLETED |

# Child Study and Treatment Center

**UPDATE**
**July, 2002**

| **Elements of the plan per law.** (Items a through h below are part of the security & safety assessment) | **Assessment** – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence. | **Plan** – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence. |
|---|---|---|
| a. The physical attributes of the state hospital including:<br>1. Access control<br>2. Egress control<br>3. Door locks<br>4. Lighting<br>5. Alarm systems | **Access control** – The receptionist is located in the center of the Administration Building, many doors are unlocked and there is no main entry.<br><br>**Egress control** – There is no egress control in the school and Administration Buildings. | **Plan** – Review options to improve access monitoring of Administration Building in Safety Committee and send recommendations to Executive Management Team, September 2000.- **Completed**<br><br>**Plan** – Review options to improve eggress control in Safety Committee and send recommendations to Executive Management Team, September 2000.- **Completed**<br>An assessment of the administration building concluded no action at this time. There are 28 entry points to the building including seven in the attached Oak Grove School. Of these, six are normally unlocked during the day. Others are accessed by select staff carrying appropriate keys.<br>There have been no known assaults or major threats to administrative staff related to the building access. Periodically, |

| **Elements of the plan per law.** (Items a through h below are part of the security & safety assessment) | **Assessment** – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence. | **Plan** – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence. |
|---|---|---|
| | | Western State Hospital patients wander in, but WSH Security responds quickly if needed. |
| | **Door locks** – Staff periodically lose keys and/or do not return them when resigning. | **Plan** – Appoint subcommittee to develop exit process to be followed by all staff leaving CSTC employment. |
| | **Lighting** – Exterior lighting has been vastly improved in the last few years, targeting parking lots and around cottages. | **Plan** – No action at this time. |
| | **Fire Alarms**, motion detection systems – Individual door alarms have been added to patient rooms when treatment programs indicate the need due to security issues | **Plan** – Improved motion detection systems are included in capital construction plans for Ketron Cottage in 2001 (but now on hold until 2002 most likely) and in Camano Cottage when the remodel is funded, probably in 2002. In addition the fire alarm system has been modified to a strobe light and removing a horn, which agitates patients and can lead to out of control/dangerous behavior. Installation in September 2000. |
| b. Staffing, including security staffing | **Assessment** – Assessment included a staff survey on factors related to violence and evidence from Critical Incident Reviews. When multiple non-permanent staff and inexperienced staff are on duty, risk of aggressive and non-cooperative behavior on the part of patients increases. | **Plan** – Each cottage has added one additional fulltime FTE, to reduce intermittent staff use when coverage is needed for sick and annual leave of staff and when higher acuity of patients requires it. |
| c. Personnel policies | **Assessment** – Assessment will be ongoing and the responsibility of Administrators. | **Plan** – None at this time, updates will be provided as needed. |

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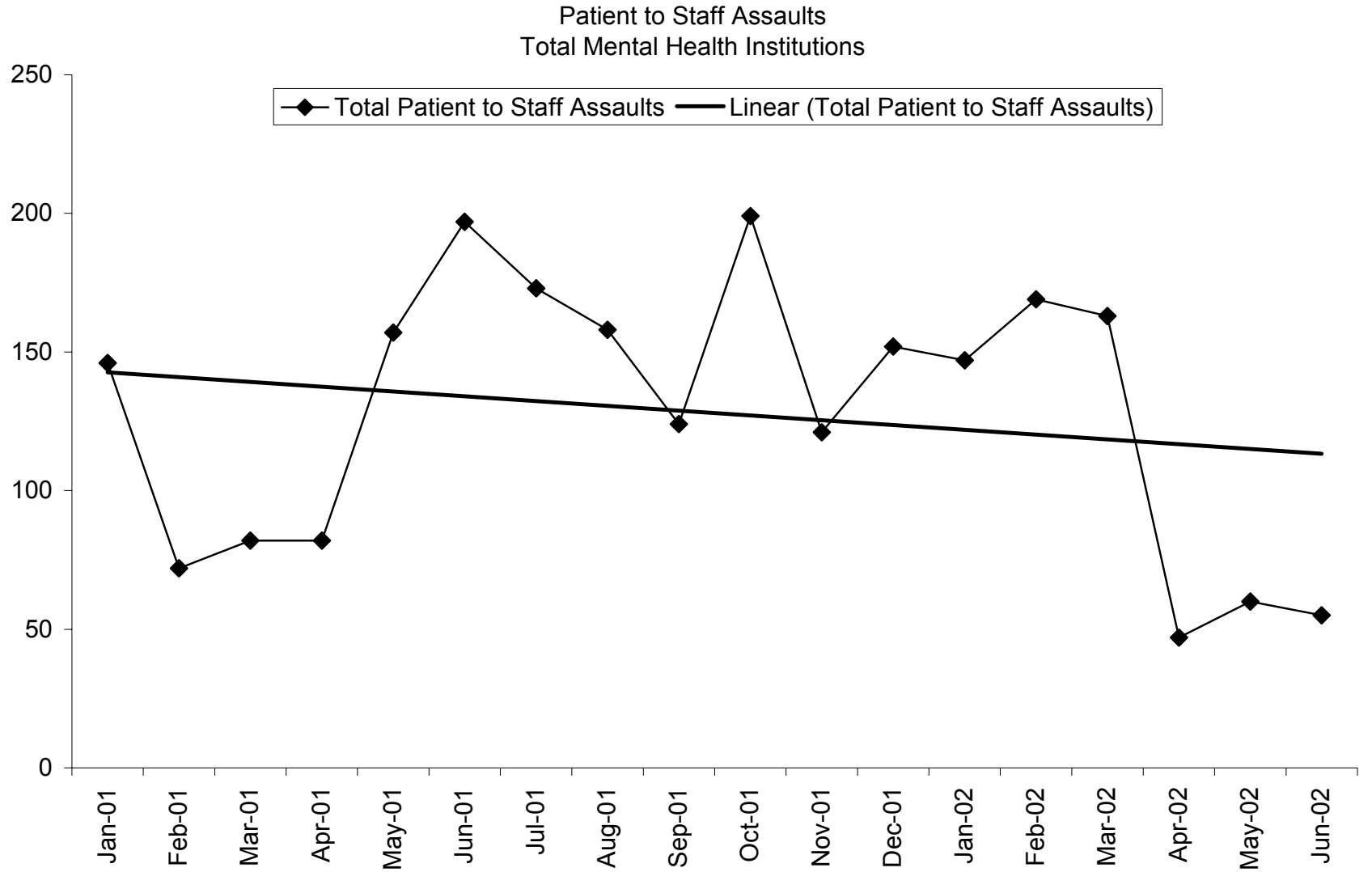
|---|---|---|
| d. First aid and emergency procedures | **Assessment** – Ongoing assessment occurs through Critical Incident Reviews and quality improvement activities. | **Plan –** Following the earthquake, management met with our assigned Safety Officer and the Plant Manager to review existing policies and procedures and to debrief the response by staff and patients. Minimal changes will be made, as existing practice seemed safe and would allow needed communication. |
| e. Violent acts:<br>1. reporting of violent acts<br>2. taking appropriate action in response to violent acts<br>3. follow-up procedures after violent acts | **Assessment** – Review procedures that are in place, including use of staff meetings to review patient incidents of violence and Critical Incident Reviews by management, defined by policy. Continued staff training needed. | **Plan** – Begin Life Space Crisis Intervention Consultation groups, made up of staff with advanced LSCI training. Designate these staff as mentors and coaches for these interventions. Start up – September 2000. Behavioral management training, targeting direct care staff was offered October - November 2000. Four clinical staff will attend advanced training in Dialectical Behavioral Therapy (a specific behavioral management psycho-educational model of treatments) in June 2001.<br><br>**Update June 2002**<br>**Plan** - A detailed assessment of recent incidents of violence toward staff and property in May 2002 in Orcas Cottage is occurring. The goal is to identify knowledge, skills and resource deficits that lead to high risk incidents. |

| **Elements of the plan per law.** (Items a through h below are part of the security & safety assessment) | **Assessment** – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence. | **Plan** – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence. |
|---|---|---|
| | | LSCI consultation groups were meeting to review incidents in which LSCI skills were used, throughout 2001. Consistency of meetings was an issue for two cottages, while Camano Cottage regularly held meetings.<br><br>Behavioral management training was held in fall of 2000 and spring of 2001. Approximately 17 staff attended 4-12 hours of training. An additional two hours of training was provided with approximately 35 staff in attendance. |
| f. Criteria for reporting verbal threats | **Assessment** – Assessment of the existing Incident Report data concluded that data presently reported could meet this requirement. | **Plan** - Beginning July 2000 medical records produces a report on the incidents of verbal threats. The report is reviewed monthly and quarterly as part of the QI Report. **Completed.** |
| g. Employee education and training | **Assessment** – Evaluation of a staff survey January 2000, periodic Critical Incident Reviews, and ongoing assessment of Incident Reports indicate a need for increased skill on the part of direct care staff. | **Plan** – Begin Life Space Crisis Intervention consulting groups and increase mentoring of new staff and those without advanced training in these techniques. September 2000.<br>Access Behavior Management Training October 2000<br>**Update April 2001** - LSCI groups were formed in all cottages to support use of the intervention skills. Behavior Management Training occurred in two hour blocks, once |

| **Elements of the plan per law.** (Items a through h below are part of the security & safety assessment) | **Assessment** – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence. | **Plan** – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence. |
|---|---|---|
| | | with each cottage staff meeting and was also offered campus wide in a more in depth, 12 hour program. |
| h. Policies and practices related to patient care. | **Assessment** – Additional program structure and access to rewarding and skillbuilding activities promises to reduce boredom and depression, which can lead to agitation of patients. | **Plan** – Hire an additional Recreation Therapist – **completed**, July 2000. Increase cottage program structure – ongoing. **Update April 2001** - Major staff turnover including some key leadership positions has slowed some program structure quality improvement efforts. New Program Directors in place as of March 2001 reviewing milieu programs. |
| Analysis of data on violence and workers compensation claims during at least the preceding year | **Assessment** – Data is available and L&I compensation incidents showed a decrease. | |
| Increase of staff training and coaching | | |
| Violence prevention training | | **Plan** – Plan in place – ongoing |
| Record of violent acts including physical assault or "attempted" physical assault | | **Plan** – Compiled monthly by medical records from Incident Reports. |
| | | **Update June 2002:** Ongoing review of milieu programming led to a number of cottage specific actions. Camano, serving the 6-12 year olds developed a quality improvement focus on increasing the recreation participation hours of patients. Ketron Cottage, 12-14 year olds, has focused on increased structure and supervision and has greatly decreased use of seclusion. Orcas Cottage, |

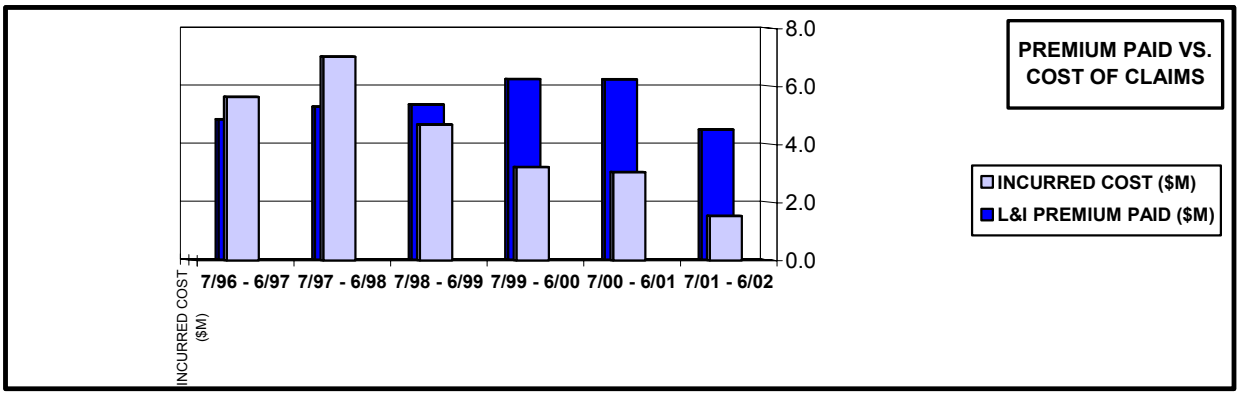
| **Elements of the plan per law.** (Items a through h below are part of the security & safety assessment) | **Assessment** – Report on the results of the security and safety assessments (and other areas of assessment as required or suggested in the law), identifying existing or potential hazards for violence. | **Plan** – Security considerations and action already taken or planned – based on the hazards identified in the assessment – to prevent and protect employees from violence. |
|---|---|---|
| | | 14-17 year old and serving many of the most high needs patients, has focused on program structure and intervention techniques that address staff safety. |

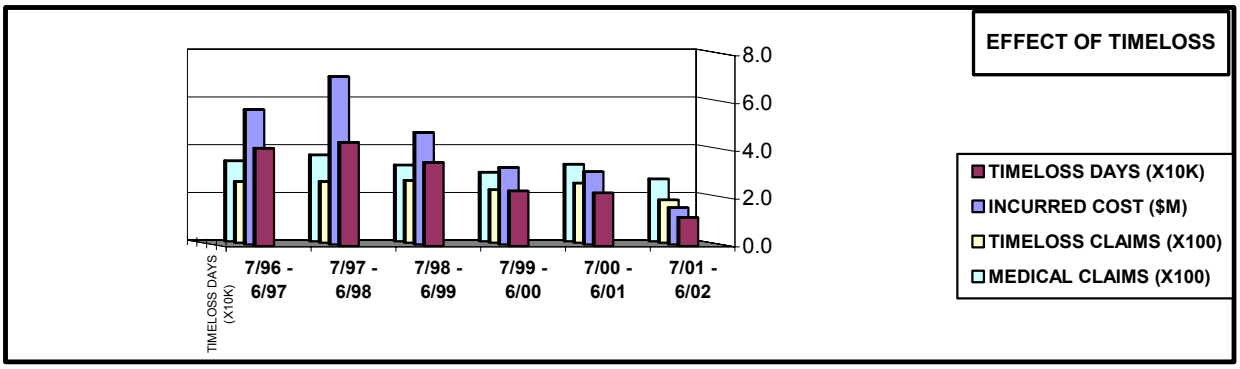
# Appendix D – Patient to Staff Assaults

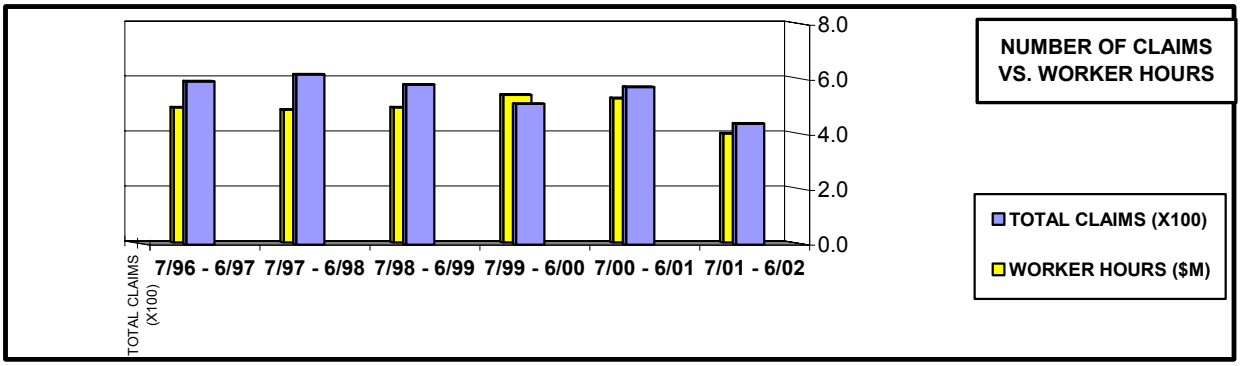



Souce: State Hospital Quarterly Rpts

# Appendix E – Industrial Insurance Claims and Time Loss Data




| YEAR | 7/96 - 6/97 | 7/97 - 6/98 | 7/98 - 6/99 | 7/99 - 6/00 | 7/00 - 6/01 | 7/01 - 6/02 |
|---|---|---|---|---|---|---|
| **WORKER HOURS ($M)** | 4.91 | 4.83 | 4.91 | 5.36 | 5.24 | 3.96 |
| **INCURRED COST ($M)** | 5.64 | 7.02 | 4.68 | 3.22 | 3.05 | 1.54 |
| **L&I PREMIUM PAID ($M)** | 4.84 | 5.27 | 5.35 | 6.22 | 6.21 | 4.48 |
| **TOTAL CLAIMS (X100)** | 5.93 | 6.18 | 5.81 | 5.11 | 5.72 | 4.39 |
| **TIMELOSS CLAIMS (X100)** | 2.57 | 2.57 | 2.62 | 2.22 | 2.50 | 1.79 |
| **MEDICAL CLAIMS (X100)** | 3.36 | 3.61 | 3.19 | 2.89 | 3.22 | 2.60 |
| **TIMELOSS DAYS (X10K)** | 4.10 | 4.34 | 3.50 | 2.31 | 2.22 | 1.19 |

Source Data: Department of Labor and Industries

Chart: John Nacht, DSHS Western State Hospital

Data Through June 2002

***NOTE: FY 02 data is subject to wide variation because the data from L&I includes estimates that are not "mature".**